VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

June 25, 2012

Mr. Phillip Condon, Administrator
Franklin County Rehab Center LLC
110 Fairfax Road
St Albans, VT 05478

Provider #: 475047

Dear Mr. Condon:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 23, 2012.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, MS
Licensing Chief

PC:ne

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475047	A. BUILDING _____ B. WING _____	05/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY REHAB CENTER LLC	110 FAIRFAX ROAD ST ALBANS, VT 05478

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced, on-site recertification survey was conducted by the Division of Licensing and Protection between 05/21/2012 and 05/23/2012. The following regulatory deficiencies were identified:	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop a comprehensive plan of care for one Resident (#29) with nutritional risks and significant weight loss and one Resident (#74) receiving psychotropic medications. This affected	F 279	F 279 – DEVELOP COMPREHENSIVE CARE PLANS The guideline for care area assessments (CAA) will be copied and shared with all members of the interdisciplinary team, and appropriate nursing personnel. They will sign that they have read and that they understand based on the CAA guidelines what should be care planned for. An inservice will be held for staff who need further education by Post Acute Consulting as soon as they can schedule one. The QA committee will sample approximately 6 patients or 10% of the patient charts for compliance with care planning guidelines. The reviews will be from previous quarter's charts. Date of completion: June 23, 2012 accepted Heffernan, RN 6/21/2012	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Phillip H. Conklin | TITLE: Owner/Administrator | (X6) DATE: 06-11-2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PMC

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F 279	Continued From page 1 two (Resident #29 and #74) of 21 stage two sampled Residents. Findings include: 1. Per record review on 05/22/12, Resident #29 was admitted on 11/28/11 and had diagnoses of diverticula of the intestine, diverticulitis of the colon, esophageal reflux, ill defined cerebrovascular disease and hypercholesterolemia. The Physician's orders did not include a nutritional supplement. An admission weight of 181.8 pounds was documented on the Resident Weight Record dated 12/01/11. Weights were documented weekly and indicated a downward trend. The most recent weight indicated on the weight record, 160.0 pounds, was dated 04/25/12. Review of the comprehensive plan of care for Resident #29 revealed no plan of care to address the Resident's risks for altered nutrition or weight loss. No plan of care was noted to include nutritional interventions to address actual significant weight loss. Interview of Resident #29 on 05/22/12 at 4:20 P.M. revealed that s/he enjoyed the food and was provided snacks whenever s/he asked for them. Interview of the Dietary Manager and the Registered Dietician (RD) on 05/23/12 at 9:15 A.M. revealed that the meal intake report indicated Resident #29 consumed 85% of the food provided during the last 30 days. Both verified that the Resident Weight Record indicated a consistent downward trend since admission. The RD indicated the weight loss of 22 pounds in less than six months constituted a significant weight loss (greater than 10%) for Resident #29. The RD and the Dietary Manager verified that Resident #29 did not receive a	F 279		

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F 279	Continued From page 2 nutritional supplement and no plan of care was available to address the risks and actual significant weight loss for Resident #29. See also F325. 2. Per record review on 05/22/12, Resident #74 was admitted on 03/21/12 with diagnoses of dementia, depression, other persistent mental disorders, chronic anxiety and recent cerebrovascular accident with left sided weakness. The Physician's orders indicated the Resident received Ativan (an antianxiety medication) 0.5 milligrams (mg) twice daily by mouth on a routine basis. Review of the comprehensive plan of care revealed no plan of care to indicate the Resident's specific symptoms that require the use of antianxiety medication, no guidance for non pharmacological interventions to reduce anxiety, no guidance related to monitoring for the opportunity to attempt gradual dose reductions or monitoring for side effects related to the use of the antianxiety medication. Interview of the Minimum Data Set (MDS) Coordinator at 2:55 P.M. on 5/23/12, confirmed that there was no plan of care developed for the use of Ativan, no plan of care to address the symptoms of anxiety displayed by Resident #74, no plan developed to use Resident specific non pharmacological interventions to decrease anxiety and no intervention identified to monitor for the opportunity to reduce the dose and assure the use of the lowest effective dose of psychotropic medication.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

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F 280	Continued From page 3 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to revise the care plan to reflect the current needs of 2 residents in the Stage 2 sample of 21. (Resident #51 and #82) Findings include: 1. Per record review and staff interview the facility failed to revise a care plan for Resident #51, who has significant weight loss. Resident #51 experienced a weight loss of 5.9% of body weight between 2/7/12 and 5/21/12. The resident was placed on Mighty Shakes (nutritional supplement) 120 milliliters twice per day as noted in the dietary	F 280	F 280 – RIGHT TO PARTICIPATE PLANNING CARE – REVISE CP The guideline for care area assessments (CAA) will be copied and shared with all members of the interdisciplinary team, and appropriate nursing personnel. They will sign that they have read and that they understand based on the CAA guidelines what should be care planned for. An inservice will be held for staff who need further education by Post Acute Consulting as soon as they can schedule one. The QA committee will sample approximately 6 patients or 10% of the patient charts for compliance with care planning guidelines. The reviews will be from previous quarter's charts. Date of completion: June 23, 2012 accepted 6/21/2012 JK Coleman, RN	

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F 280	Continued From page 4 note on 2/1/12. The resident care plan was not updated to reflect the addition of a dietary supplement. The finding was confirmed with the RD on 5/23/12 at 11:40 A.M. 2. Per record review on 05/22/12, Resident #82 was admitted on 02/21/12 with diagnoses of Alzheimer's dementia and high risk for falls related to a history of frequent falls prior to admission. Review of the Nurse's Notes revealed that Resident #82 had a fall with no injuries on the way to the bathroom at 7:00 A.M. on 03/28/12. The note dated 04/12/12, 7-3, indicated that staff was responding to a sounding alarm and observed Resident #82 standing at the foot of the bed. The Resident was lowered to the floor without injury. The note dated 05/13/12 at 7:10 A.M. indicated that Resident #82 was observed sitting on the floor at the foot of the bed with a small abrasion to his/her back. The notes do not indicate any change was made to the plan of care to attempt to minimize the number falls or prevent injuries as a result of falls. Throughout the nurse's notes, it is documented that Resident #82 frequently transfers without assistance and sets off alarms that have been placed to alert staff. Review of the plan of care for high risk for falls dated 02/21/12 reveals interventions implemented at the time of admission include: fall assessment, maintain safety (call bell in reach, bed in low position, proper lighting, appropriate footwear, alarms), 1/4 side rails for bed mobility, assess drugs that may cause falls, 1:1 as needed, involve in activity programs as tolerated, document behaviors and side effects, chair and bed and tab alarm. The plan of care indicated that a fall occurred on 05/13/12 and indicated a toileting schedule was initiated every two hours to decrease falls. The schedule was not listed.	F 280		

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F 280	Continued From page 5 Interview of the Director of Nursing Services (DNS) on 05/23/12 at 1:30 P.M. revealed that the note for the fall of 04/12/12 should indicate the fall occurred at 7:00 A.M. The DNS confirmed that all three falls happened close to 7:00 A.M. and no intervention specific to 7:00 A.M. had been initiated. The DNS confirmed that the falls dated 03/28/12 and 04/12/12 were not reflected on the plan of care and no interventions were changed or added as a result of the falls.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on review of medication records and physician's orders and interview, the facility failed to withhold a medication according to parameters prescribed by the physician. This affected one (#29) of 10 stage two sampled residents with drug regimen reviews. Findings include: Per review of the Medication Administration Record (MAR) for Resident #29 on 05/22/12, it was noted to clearly read, metoprolol (a beta blocker used to control high blood pressure and/or chest pain) 50 milligrams (mg) by mouth twice daily. Hold for pulse less than 60. This was confirmed in the physician orders located in the clinical record. On 05/06/12 at 8:30 A.M., the record indicated by initials, that metoprolol had been administered and the pulse was recorded as 56. On 05/13/12 at 4:00 P.M. the initials	F 281	F – 281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS We will inservice all professional nurses on proper charting for medication administration. This will be done by having all professional nurses read the medication administration guidelines and signing off that they have done so. Inservice will be held by the pharmacist based on availability. The pharmacist and administrative nurses will do ongoing MAR QA tests for adherence to the guidelines at least monthly. Date of completion: June 23, 2012 accepted 6/21/12 A Coleman RN	

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F 281	Continued From page 6 indicated administration of metoprolol and the pulse was recorded as 56. Interview of the Registered Nurse (RN) unit manager on 05/22/12 at 3:15 P.M., revealed that the nurses were to circle the initials if a medication was withheld and document the reasons on the back of the MAR for any routine medications not administered or any as needed medications that were administered. S/he confirmed that there was no documentation on the MAR to indicate the metoprolol was withheld in accordance with the physician's order. S/he confirmed that the nurse's notes for 05/06/12 and 05/13/12 did not indicate that the medication was withheld or that the physician was notified of the need to withhold the medication on those dates. The findings were confirmed by the Director of Nursing Services (DNS) on 05/22/12 at 4:20 P.M. during interview, after s/he had reviewed the record. See also F329.	F 281		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325	F 325 – MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE The dietitian or her designee will give an inservice on nutritional assessments and the importance of care planning for weight loss. The dietary manager and dietician will assess all weights monthly and check that any weight loss or weight gain has been care planned for. Date of completion: June 23, 2012 accepted 6/21/2012 KColeman RN	

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F 325	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview and clinical record review, the facility failed to identify a significant weight loss and intervene appropriately for one Resident. This affected one (#29) of three stage 2 sampled residents reviewed for significant weight loss. Findings include: Per record review on 05/22/12, Resident #29 was admitted on 11/28/11 and had diagnoses of diverticula of the intestine, diverticulitis of the colon, esophageal reflux, ill defined cerebrovascular disease and hypercholesterolemia. The Physician's orders did not include a nutritional supplement. An admission weight of 181.8 pounds was documented on the Resident Weight Record dated 12/01/11. Weights were documented weekly and indicated a downward trend. The most recent weight indicated on the weight record, 160.0 pounds, was dated 04/25/12. Review of the comprehensive plan of care for Resident #29 revealed no plan of care to address the Resident's risks for altered nutrition or weight loss. No plan of care was noted to include nutritional interventions to address actual significant weight loss. Review of the dietary progress note dated 11/28/11 revealed, under nutritional related problems and approaches heading, that Resident #29 was at risk for altered intake and fluid status related to requiring ground meat and honey thickened liquids and was at risk for aspiration. The interventions included diet textures and liquid consistency per speech therapy	F 325		

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F 325	Continued From page 8 recommendations, offer liquids throughout the day and consider magic cup supplement while on honey thickened liquids. A note on 12/05/11 indicated a diet change to honey liquids with no bread and continued coughing episodes. On 12/06/11 a notation indicated the diet was again changed to a pureed texture with continued honey thickened liquids and no straws. A note written on 02/29/12 indicated the Resident's weight on 02/15/12 was 167.2 pounds, on 02/22/12 the weight was 165.4 pounds and on 02/28/12 the weight was 170.2 pounds. The note indicated a chronic cough was reported and Resident #29 remained at risk for aspiration. The RD documented the overall oral intake was approximately 55% and no recommendation was made. No reference was made to indicate the RD recognized the continued weight loss or made any recommendation to address the decreased oral intake. Review of the weight record for Resident #29, that was easily located in the clinical record, indicated that weights had been recorded weekly. No weight was documented on 02/28/12 and the weight recorded on 02/29/12 was 160.8 pounds, continuing a downward trend. Interview of Resident #29 on 05/22/12 at 4:20 P.M. revealed that s/he enjoyed the food. The Resident indicated that routine snacks were not provided but stated that snacks were available whenever s/he asked for them. Interview of the Dietary Manager and the Registered Dietician (RD) on 05/23/12 at 9:15 A.M. revealed that the meal intake report indicated Resident #29 consumed 85% of the food provided during the last 30 days. Both verified that the Resident	F 325		

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F 325	Continued From page 9 Weight Record indicated a downward trend since admission. The Dietary Manager stated that the facility began computerized documentation in February 2012 and the RD and the Dietary Manager must have looked only at the computerized documentation without considering the Resident's weight history prior to February. S/he indicated the Resident's weight was obtained on 05/23/12 and was recorded at 159.0 pounds. The RD indicated the loss of 22.8 pounds in less than six months constituted a significant weight loss (greater than 10%) for Resident #29. The RD and the Dietary Manager verified that Resident #29 did not receive a nutritional supplement and no plan of care was available to address the risks and actual significant weight loss for Resident #29. See also F279.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329	F 329 – DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS We will inservice all professional nurses on proper charting for medication administration. This will be done by having all professional nurses read the medication administration guidelines and signing off that they have done so. Inservice will be held by the pharmacist based on availability. The pharmacist and administrative nurses will do ongoing MAR QA tests for adherence to the guidelines at least monthly. Date of completion: June 23, 2012 accepted 6/21/2012 KJC manager	

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F 329	Continued From page 10 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on review of medication administration records and interview, the facility failed to consistently document monitoring of a pulse for one Resident (#29) with physician's orders for specific parameters to withhold the medication and administered two doses when the pulse fell outside the prescribed parameters. This affected one (#29) of ten stage two sampled Residents with medication regimen reviews. Findings include: Per review of the Medication Administration Record (MAR) for Resident #29 on 05/22/12, it was noted to clearly read, metoprolol (a beta blocker used to control high blood pressure and/or chest pain) 50 milligrams (mg) by mouth twice daily. Hold for pulse less than 60. This was confirmed in the physician orders located in the clinical record. A space was provided on the MAR for the nurse to initial after administration and a space was provided to record the pulse. The MAR for May 2012 was blank (no initials recorded) for the dose on 05/10/12 at 4:00 P.M. and a pulse recorded as 90 was crossed out. There was no indication on the back of the MAR or in the nurses notes if the medication had been	F 329		

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F 329	Continued From page 11 administered or not. The MAR indicated that metoprolol had been administered with a pulse below the parameter of 60 beats per minute on 05/06/12 at 8:30 A.M. and 05/13/12 at 4:00 P.M. The MAR for April 2012 was reviewed and initials were noted, indicating the medication was administered, with no pulse recorded for five doses (the 8:30 A.M. dose on 04/06/12 and the 4:00 P.M. dose on 04/01/12, 04/03/12, 04/07/12, and 04/20/12). Interview of the Registered Nurse (RN) unit manager on 05/22/12 at 3:15 P.M., revealed that the nurses were to circle the initials if a medication was withheld and document the reasons on the back of the MAR for any routine medications not administered or any as needed medications that were administered. S/he confirmed that there was no documentation on the MAR to determine if the metoprolol was, or was not, administered in accordance with the physician's order because the pulse was not documented for five doses. S/he confirmed that the nurse's notes did not indicate that the pulse was assessed and within the parameters prescribed, on the corresponding dates. S/he confirmed that the metoprolol had been administered with the pulse outside the ordered parameters on two occasions in May 2012. The findings were confirmed by the Director of Nursing Services (DNS) on 05/22/12 at 4:20 P.M. during interview, after s/he had reviewed the record. See also F281.	F 329		
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475047	A. BUILDING _____ B. WING _____	05/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY REHAB CENTER LLC	110 FAIRFAX ROAD ST ALBANS, VT 05478

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 12 The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to post, in a prominent place readily accessible to residents and visitors, information which included the daily resident census. Findings include:	F 356	F 356 – POSTED NURSE STAFFING INFORMATION The receptionist will be given and educated in the recording requirements. It will be checked by the Administrator or his designee on a weekly basis. The QA committee will review the document quarterly at the QA meetings. Date of completion: June 23, 2012 accepted 6/21/2012 Coleman, RN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475047	A. BUILDING _____ B. WING _____	05/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY REHAB CENTER LLC	110 FAIRFAX ROAD ST ALBANS, VT 05478

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 13 Per observation and staff interview the facility failed to post information daily which includes the resident census. The posted information included the required staffing information but did not include the daily resident census. In an interview at 9:45 AM on 5/21/12 the Facility Clerical and Records Coordinator, who is responsible for posting the staffing information stated, "The resident census is there (on a sheet on the desk, not accessible to the public). I didn't know I had to include the resident census on this sheet . I thought it was the staff census.". The Administrator, who was present, stated that s/he thought that the resident census was being posted on the sheet.	F 356		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475047	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 5/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN COUNTY REHAB CENTER LLC	**110 FAIRFAX ROAD ST ALBANS, VT**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interview the facility failed to ensure the accuracy of the MDS (Minimum Data Set) for 1 of 21 residents in applicable sample (Resident # 20). The evidence includes:

Per medical record review on 05/23/2012 at 10:00 am the MDS assessment for Resident #20 dated 11/25/2011 codes the resident as 03 "always incontinent" in the section titled urinary incontinence (HO 300), not 09 which would indicate "not rated as resident has a Foley." The MDS indicates a diagnosis of neurogenic bladder. The next MDS, dated 12/13/2011 codes the resident as 09 or "not rated as resident has a Foley". The MDS dated 12/28/2012 codes the Resident #20 as a "0" as always continent.

The MDS nurse confirmed during interview on 05/23/2012 at 10:15 am that the MDS coding of 12/28/2011 is incorrect and should be "09".

The above isolated deficiencies pose no actual harm to the residents